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ABSTRACT

Many training programs have been set up for volunteers and paraprofessionals who work with the elderly. These programs, however, tend to emphasize basic helping skills. Those already trained in basic psychotherapeutic techniques require advanced training in skills related to psychotherapy and counseling with older adults. The effectiveness of such a training program designed to teach mental health professionals advanced therapy skills with elderly patients was examined with 53 female and 3 male participants. Participants showed statistically significant improvement on the two major assessment devices after completion of the training program. Concomitantly, job satisfaction and perception of preparedness for employment as counselors to the elderly were affected in a positive direction, providing supporting evidence as to the efficacy of the program. The impact of the training was also sustained at the two-month follow-up. Regression analyses revealed that the trainee characteristics most predictive of success in the program were those having to do with prior knowledge and skill: those entering the program with higher levels of expertise tended to improve and learn more in training. (Author)

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Psychotherapy with the Elderly:
A Training Program for Professionals

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Recently there has been an upsurge of interest in the mental health of the elderly. Surveys indicate, for example, that 30% of the population of mental hospitals are 65 or over; four percent of all patients treated in community mental health centers are 65 or over; and two percent of all patients treated in mental health clinics are 65 or over (1). These statistics dramatically illustrate our relative neglect of this age group. Since the aged are even less likely to seek out psychiatric services than their younger counterparts, we need to attend to the provision of services offered both within the clinic setting and within clients' homes and apartment communities.

While many gerontologists call for mental health services tailored to older persons, Kastenbaum has questioned the need for the development of "geriatric psychotherapy" (2). He suggests that practitioners treat the common problems experienced by young and old using essentially the same approaches for both age groups. Although this viewpoint appears practical, Lawton has argued cogently that specialized training for mental health professionals in gerontology and geriatrics can improve older persons' access to the mental health system and at the same time enhance the quality of care they receive (3).

A number of training programs have been set up for volunteers and paraprofessionals who work with the elderly. These generally emphasize basic helping skills along with some material pertaining to biological, sensory, and psychosocial aspects of aging. For professionals, however, who already have training and experience

in basic psychotherapeutic techniques and who wish to enhance their expertise with the elderly, there are few options. While advanced-level institutes and workshops are offered occasionally, many of these focus on assessment and diagnosis rather than on psychological treatment.

The Arlington (Virginia) Area Agency on Aging recognized this problem as they began to receive increasing numbers of requests for specialized training from professionals. The agency contacted us and asked that we present a relatively brief and inexpensive program designed to teach advanced skills concerning psychotherapy with the elderly to mental health professionals. We subsequently requested and received Title IA Continuing Education funds to develop and implement this program which was based at Virginia Tech's Northern Virginia Center for Graduate and Continuing Education at Dulles International Airport.

Recruitment and Description of Participants

The program was advertised in brochures as purposing to "increase the effectiveness of mental health professionals in their work with elderly persons through advanced training in treatment considerations and techniques which are especially important with older people." Detailed brochures with registration forms were sent to hospitals, clinics, and community agencies throughout Northern Virginia two months before training began. A registration limit of 50 was set and the program filled to capacity.

Of these 50 persons, 47 attended the initial sessions. Sixteen were social workers, 10 were Registered Nurses, four had master's degrees in sociology and psychology, one was a psychiatrist, and the

remaining 16 came from a variety of educational backgrounds. There were 43 women and four men, with an age range of 23 to 56 years and an average age of 37. The average number of years of education was 17. All reported having had formal training in and experience using basic psychotherapeutic skills. Participants were all currently working with elderly clients and were employed at various county agencies, hospitals, community mental health centers, Visiting Nurse Associations, and Area Agencies on Aging.

Participants were divided into two groups, one with 24 and the other with 23 members. The same trainers, a clinical psychologist and a graduate student in psychology, met with both groups. The training program was divided into four three-hour sessions: one Monday, one Tuesday, and the remaining sessions two weeks later on the same days.

A number of measures were administered both before and after the program to determine trainees' original level of expertise and to evaluate the effectiveness of our training. We devised the major assessment instrument, which was composed of eight brief descriptions of situations commonly encountered in the psychological treatment of the elderly. For this "Counseling Situations" measure trainees were asked to write a description of their preferred treatment plan, including options and alternatives, for each problem situation. After the program two raters independently and blindly rated each participant's answers on a scale designed to assess the appropriateness of the plans. Interrater reliability was high (r = .88).

We also developed and administered a Mental Health Information Test designed to measure general background knowledge concerning the mental health of older people. In addition, since we were interested in the impact our program might have on participants' perceptions of their jobs, we added two work measures. One consisted of a question in which subjects were asked to rate their level of preparedness for their current job positions on a 10-point scale. The other was a brief measure of job satisfaction (4). The final instrument administered assessed attitudes toward the elderly (5).

At the end of the program participants anonymously completed questionnaires designed to evaluate program content and method. Two months later materials were mailed to trainees to assess maintenance of gains made during training. This follow-up package included the Mental Health Information, Job Preparedness, and Job Satisfaction measures, and another workshop evaluation. The Counseling Situations Test was not sent because of the large amount of time it takes. We felt that its inclusion might significantly lower the return rate of the follow-up package.

Program Description

During the training program we consistently tried to present information verbally and visually. A number of hand-outs were distributed so that trainees could spend more time listening and participating and less time taking notes.

Session 1 began with a brief introduction and the administration of the evaluation measures. Training commenced with an overview of mental health and aging that included general information on adaptive tasks in later life, maladaptive coping strategies, statistics

on the incidence of psychopathology among older people, and descriptions of common functional psychiatric disorders among the elderly.

We introduced the subject of psychotherapy with a description of common myths surrounding the aged such as those of resistance to change and unresponsiveness to therapy. We then turned to studies concerning personality in later life, emphasizing the stability of individual personality across the life span and the heterogeneity of the elderly. This led to a discussion of common general themes in therapy with older people. We included the following: coping with loss, recognizing fears concerning death, wishes for new starts and second chances, and wishes to undo previous life patterns. Our next topic focused on the importance of assessment when elderly are referred for treatment. Included here were such areas as physical health, family and personal history, response to developmental tasks and past crises, and present capacity for social functioning. We mentioned that once a problem area has been delineated by patient and therapist, usually one or more of the following common goals are set: symptom relief, adaptation to a changed life situation, acceptance of a more dependent status, and active engagement in a variety of activities.

After discussions of assessment and goal-setting as described, we went over several basic psychotherapeutic techniques that are especially useful in establishing the initial therapeutic relationship with older persons. Among these were showing interest at the outset of therapy by scheduling frequent sessions or phone calls the first month, allowing the patient to discuss seemingly mundane daily problems and physical ailments, and contacting

important family members if the patient supports it. In addition, special attention must be given to getting to know and understand the world of the elderly individual. Given the prevalence of ageism in our society, it is also important that therapists recognize their own feelings about aging and the elderly and the impact these may have on treatment with persons in this age group.

We concluded this first session with a section on life review, or reminiscence. Participants were encouraged to advise family members of the elderly to stimulate life review in their older relative using techniques such as empathic listening, focusing, and exploration. We also provided a number of suggested activities which can be carried out by the patient and which will result in reminiscing.

Session 2 began with an overview of a literature search we conducted to identify commonly proposed modifications of therapeutic techniques to use when counseling the elderly. Table 1 contains a summary of these suggestions. The rationale for each modification was discussed and participants were eager to relate their own experiences with such modifications.

Insert Table 1 about here

We changed topics at this point and introduced a general treatment outline to use as a base for presentations of specific treatment techniques. The outline consisted of six basic steps: (1) gather basic information; (2) clearly delineate problems; (3) choose the most pressing problem to being working on; (4)

understand the development of the problem with the patient; (5) consider various solutions with the patient and possibly the family; and (6) implement the solution(s) most likely to work. We then presented five major psychological problems which elderly often experience and alternative solutions for each. These major categories were paranoia, confusion, anxiety, loss and grief, and behaviors that annoy or worry others. After this relatively brief presentation, the group was divided in half so that either 11 or 12 participants went with each trainer to a different room.

The trainers introduced the notion of role playing and described a brief situation involving an older person with symptoms of paranoia who was referred for treatment. Two participants agreed to play the roles of the therapist and the elderly individual respectively. It was assumed that the assessment phase had been completed and that paranoia was the problem chosen to begin work on. The "therapist" was instructed to investigate alternative solutions with the "patient," being careful to use previously suggested techniques. Our alternative solutions for paranoia were to consider the possibility that the fears may be realistic, to check for sensory impairments and adequate nutritional intake, and to increase attention and social contact. The rest of the group was asked to provide feedback to the role players after they finished. The purpose of this exercise was to make the techniques, problems, and solutions "alive" for participants, to help them identify potential difficulties often encountered in real life treatment, and to enable them to practice and to receive constructive feedback. Although the trainers provided sample situations for each problem, participants were also encouraged to use their own relevant experiences. The remainder

of Session 2 was spent in discussion, role playing, and feedback for paranoia and the next two categories, confusion and anxiety.

For confusion, we advised checking for overmedication and/or drug side effects, checking for sensory impairments, reality therapy, and reassuring the client that he or she is not going crazy. Since physical illnesses often cause confusion in the elderly, the importance of a medical examination was stressed again. Anxiety is a broad category which we broke down into three components. For anxiety caused by insomnia, we suggested that therapists advise patients to reduce daytime napping, cut down on coffee, tea and soda, check for drug side effects which might cause insomnia, and try keeping the radio, television, or lights on at night. Therapists should also attempt to increase the amount of attention the patient receives from important others and to increase the amount of control the patient has over his or her environment (e.g., bedtime). Anxiety over death and dying can often be relieved via open discussion of feelings, allowing the patient to set the limits, allowing some death denial, and discussing the necessity for honesty with the family. For anxiety over body functioning such as elimination and incontinence, irrational ideas, and over-concern, alternative solutions include increased attention from significant others, changing the diet (e.g., less liquid before bed), special pads, regular toileting, information and education concerning body functioning, and checking to see if another person, possibly a family member, is increasing the patient's anxiety.

Session 3 began with a brief recapitulation of the previous session and proceeded into small group discussions and role playing for the remaining major problem categories. For the first of these, loss and grief, we listed the following solutions: increase attention,

social contacts, and activities; listen attentively and give sympathy; tell the family what is needed; involve the patient in a group, for example, for widows; and be on the alert for the possibility that the normal grief reaction may develop into more serious depression. The final problem category was behaviors that annoy or worry others, such as talkativeness and clinging, nagging and repeated questions, restlessness, sexual misbehavior, stealing, and violence. Alternatives here were to increase affection and physical contact, to increase attention and social contact, to increase satisfying, useful activity, and to provide reassurances and confirmation of reality.

Toward the end of the third session both groups completed the small group exercises and gathered together again. The trainers introduced three additional areas with which psychotherapists for older people should be familiar: suicide, organic brain syndromes, and effects of drug therapy. For the former, we described danger signals, statistics for suicide among the elderly, and crisis intervention strategies which have proved effective in the past. For organic brain syndromes, we presented basic background information, statistics, descriptions of symptoms, and treatments. For the acute syndrome, the removal of the causative agent was emphasized. For the chronic syndrome, while recognizing that basic cognitive dysfunctions cannot be reversed, we described the positive effects that psychotherapy and/or warm, caring relationships can have. Our comments on drug therapy centered on common signs of overmedication, descriptive statistics, and special dangers for the elderly in drug therapy. The importance of having the patient's physician cognizant of all

medications being taken was mentioned, as was the usefulness of helping the patient devise a method to keep medication schedules and dosages straight.

Session 4 focused on the family of the elderly patient, since many families are closely involved with their aging relatives and should be included in treatment whenever possible. General topics included the role reversal of the parent-child relationship, effects of time on marriage and family relationships, the dependency/independency of the elderly, and family decision-making processes concerning the care of the older relative. We also considered concrete issues such as deciding between independent living, living with community supports, and institutional living. Advantages and disadvantages of each level of support were discussed, as were types of services and facilities generally available. The psychological treatment of the nursing home patient and the value of family support were considered. Finally, the trainers presented suggestions designed to help families and the older parent cope with the dealth of the elderly parent's spouse, the imminent death of the older parent, and the older parent's remarriage or alternate live style. The program ended with a general wrap-up and with the participants' completion of the post-training evaluation measures.

Program outcome

In order to assess the impact of the training program, t tests comparing mean pre-training scores with mean post-training scores were computed. Analyses indicated that participants showed statistically significant improvement on both the Counseling Situations measure and the Mental Health Information Test after completion of the training

program. In addition, participants showed marginally significant gains on job satisfaction and preparedness. T tests comparing mean post-training scores with data collected at the two month follow-up revealed that the gains made in training were maintained.

Regression analyses, which allowed the investigators to determine which variables would best account for the participants' success on a dependent measure, were performed. To ascertain those variables which best predicted post-training scores on the Counseling Situations measure, first the pre-training scores for the Counseling Situations measure were entered into the regression equation. This, in essence, controlled for participants' pre-existing expertise. As would be expected, pre-training scores were the best predictors of success on the post-training measure, accounting for 31.6% of the variance. With this accounted for, three other variables were then entered into the equation in a stepwise fashion. Only the Mental Health Information Test added significantly to the predictive ability of the regression equation. As the second-best predictor of success on the Counseling Situations measure, the Mental Health Information Test added 13.1% of the variance to the equation, for a total of 44.7% of the variance accounted for. When the other variables, attitudes toward the elderly and job satisfaction, were added into the equation, they did not significantly improve the predictive ability of the equation.

Discussion

The results of this study suggest that the training program was effective in improving participants' knowledge about mental health and their ability to devise appropriate treatment plans for elderly clients. Concomitantly, job satisfaction and perception of preparedness

for employment as counselors to the elderly were affected in a positive direction, providing supporting evidence for the efficacy of the training program. The impact of the program appeared sustained at the two month follow-up.

It is interesting to note that the trainee characteristics which were most predictive of success in the program were those having to do with prior level of information and skill. That is, those participants entering the program with a higher level of skill and information tended to improve and learn more in training. One explanation for this finding is that those participants having a higher level of skill and information at their disposal had the necessary foundation upon which to base advanced training, whereas others doing more poorly on pre-training measures did not. This explanation is supported by the finding that variables such as attitudes toward the elderly and job satisfaction were not significant predictors of success in training. Alternate explanations meriting consideration are that trainees who did better on pre-training measures and who improved more during training were more motivated and/or better able to learn the material presented in training. Whatever the reasons for success, it may be advantageous in future similar projects to screen applicants on prior knowledge abouth the mental health of the elderly. This would allow the trainers to obtain a more homogeneous groups of trainees, providing an optimal basis for maximizing training gains.

Anonymous evaluative data collected from program participants revealed that 70% of the participants felt that the program had been "very valuable," 22% felt that it had been "moderately valuable" and 8% felt that the program was "fair." At the two month follow-up, 43% rated the utility of the information and techniques learned in

the program as very useful, while 57% found the information and techniques moderately useful. Thus,all participants found that the course had provided them with relevant material that proved beneficial in their job settings.

There were several common responses describing the best features of the program. Participants found the participatory nature of the program (e.g. open discussions, role playing, sharing ideas, meeting with others who work with the elderly) and the training materials (handouts) to be the strongest assets of the program. Participants' suggestions for improving the program included the use of videotaping for corrective feedback, the use of case studies, and additions to the content such as family therapy and more on death and dying.

Future evaluators of this type of program should focus on the following: (1) comparisons of professionals who did and did not receive this training; (2) more convergent assessment measures, such as behavioral observations on the job and peer and supervisor ratings; (3) ongoing assessment rather than pre-post assessment, which can then be used for competency-based programs; (4) direct assessment of the transfer of the acquired skills to real-life situations; (5) comparisons of the effectiveness of training with various types of participants; and (6) tailoring the program to suit the needs of a variety of professionals working with the elderly.

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Footnotes

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Table 1

Modifications of Therapeutic Technique to Use When Counseling the Elderly

1. More active therapist role.
2. Have specific goals (be problem-oriented).
3. Briefer sessions.
4. Warm personal relationship, including touching.
5. Work with the family.
6. Special sensitivity to how therapist's feelings about old age affect the relationship, and how age difference affects therapy.
7. Work on reality problems (financial, etc.) as well as feelings.
8. Use telephone sessions and home visits.
9. Encourage life review (reminiscence).
10. Frequent sessions, especially first month.
11. Do not set a time limit on therapy.
12. Deal with one problem at a time, emphasizing you will get to others later.
13. Be informal.
14. Share personal information, if asked, or if it seems appropriate.
15. Be patient, go slowly.
16. Allow the patient to discuss physical problems and everyday events.